STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155738	A. BUILDING 00 B. WING	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILTON HOME, THE	206 E MARION ST SOUTH BEND, IN 46601

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00389408. Complaint IN00389408 - Substantiated. Federal/state deficiency related to the allegations are cited at F686 . Survey dates: September 12, 13 and 14, 2022 Facility number: 001141 Provider number: 155738 AIM number: 200905640 Census Bed Type: SNF/NF: 30 Residential: 11 Total: 41 Census Payor Type: Medicare: 4 Medicaid: 21 Other: 5 Total: 30 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 9/21/22.	F 0000		
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to provide services, such as assessments and wound dressing changes, to promote the healing of a unstageable/full thickness pressure ulcer and Moisture Associated Dermitis for 1 of 3 residents reviewed for pressure ulcers/altered skin conditions. (Resident B) Finding includes: On 9/12/22 at 10:45 A.M., a review of the clinical record for Resident B was conducted. The record indicated the resident was admitted on 5/5/22 and left the facility Against Medical Advice (AMA) on 6/14/22. The resident's diagnoses included, but were not limited to: Parkinson's Disease, cancer-melanoma of skin, severe septicemia-septic shock, dysphagia, and history of a fusion of the spine. The Minimum Date Set (MDS) Admission Assessment, dated 5/10/22, indicated the resident weighed 144 pounds, required limited assist of 1 person with bed mobility, was always incontinent of bowel/bladder, was admitted with an unstageable pressure ulcer (full thickness tissue loss), which was covered by slough (dead yellow tissue) and or eschar (necrotic brown/black devitalized tissue).	F 0686	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident B no longer resides in the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by alleged deficient practice • Full house skin sweep completed with any new or abnormal assessments documented and reported to the Physician, • Audit of all current wounds completed to ensure all assessments are completed and all treatments are appropriate and being completed as ordered • Audit completed of all residents to ensure all who are at risk for skin breakdown have preventative interventions in place and that	10/13/2022

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	A care plan, dated 5/5/22, indicated the resident had the potential and/or actual skin issues related to: resident was admitted with wound. The interventions include: "...Notify MD [Medical Doctor] of changes in the wound or emerging wounds. Observe wound healing. Provide wound care/preventative skin care per order. Skin checks weekly per facility protocol, document findings. Treatment of skin conditions per physician orders. Turn and reposition frequently to decrease the pressure...." A Nurse's Transfer/Discharge Condition Assessment Form, dated 5/5/22, from the hospital indicated " ...Peri area rash, coccyx unstageable ...." There were no measurements of the wound documented on this form. An Extended Care Facility Patient/Resident Transfer Form-Physician Orders, dated 5/5/22, from the hospital indicated, in the treatment section, the following: " ...Coccyx: unstageable, cleanse with NS [Normal Saline]. Apply Medi-honey, then cover with alginate & foam dressing every other day ...." Form indicated resident was to be seen by his primary care physician within 2-3 days. An Admission/Readmission Evaluation Form, dated 5/5/22 at 2:59 P.M., within the Special Instructions section, was the following information, " ...Resident admitted to the skill unit due to weakness and UTI [Urinary Tract Infection]. Resident will need therapy to assist him with ambulation, transfer, and bed mobility so as to strengthen his muscles and resolve open area to the coccyx...." The Skin assessment indicated the resident had an unstageable wound on his coccyx. There were no markings on the diagram to specify location and no measurements		interventions are listed in the care plan and kardex • Nursing educated on preventative wound care with emphasis of importance of placing skin preventative interventions such as floating heels and pressure relieving boots. • Nursing staff educated on use of care plan and kardex and what interventions are listed and in place for each resident • Nursing educated on the importance of following physician wound treatment orders • Nursing staff educated on the wound and wound prevention policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • DON /designee will validate treatments and ordered supplements are given / completed as ordered • Wound team to make weekly rounds on residents identified with skin impairment to ensure treatments continue to be completed per order and devices are in place for prevention of skin breakdown, notify Physicians as changes are needed and that the plan of care is current/up- dated as needed. • DON/designee will conduct random rounds weekly to ensure preventative pressure relieving devices are in place per plan of	

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	of the impaired coccyx area. A Braden Scale for Predicting Pressure Sore Risk form, dated 5/5/22 at 2:59 P.M., indicated the residents Braden score was 13. The scale indicated a score of 13-14 revealed the resident was at moderate risk of obtaining a pressure ulcer. A Progress Note, dated 5/5/22 at 3:11 P.M., indicated the writer had received report from the hospital regarding Resident B. The Note indicated the resident had rash to his peri area (genital area) and a pressure ulcer to his coccyx, which was described as unstageable. A Progress Note, dated 5/5/22 at 4:26 P.M., indicated the resident had arrived from the hospital, was alert and oriented to person place and time, with some confusion, but cooperative with the assessment. The Note indicated the resident's skin was intact, except for open area on his coccyx which measured 2.0 x 2.0 cm (centimeters) and was cleansed and then dressed with a mepilex (an absorbent foam dressing for draining wounds). A Physician Note/Exam form, dated 5/5/22, indicated the resident was seen at the facility due to being a new admission. The form's skin assessment indicated the resident had no cellulitis. There was no mention of the pressure ulcer and/or treatment on this form. A Nutritional Assessment, completed by the Dietician, dated 5/6/22 at 4:39 P.M., indicated resident had open area on his coccyx. The Dietician's recommendations were to start Prostat (nutritional supplement) 30 ml (milliliters) twice a day, for wound healing.		care • DON/designee will conduct random rounds weekly to ensure treatments / dressing are in place • DON/designee will conduct random rounds weekly to ensure that all wound assessments and wound documentation is completed • DON/designee will conduct audits on all new admissions to ensure that wounds are identified, and wound policy is followed How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • The DON/Designee is responsible for the completion of the Skin/ Wound Audit weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee, overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance Date of Compliance: 10/13/22	

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	The Skilled Charting form, dated 5/7/22, indicated resident had a wound to the coccyx area and treatment per orders. " ...Resident admitted to the facility from the hospital due to weakness and UTI [Urinary Tract Infection] which is being treated with Levaquin 750 mg[milligrams]. He requires one person assist with bed mobility, transfer, toileting and set up with meal. Resident was assessed by therapist today and found to be unable to walk well due to Parkinson disease. He is to use wheelchair until he gets enough strength as he froze while walking. He can feed self with set up. Resident is able to express his need and was educated about his need to use the call light when he needs assistance ...." A Weekly Wound Observation form, dated 5/16/22 at 7:49 P.M.,, indicated Stage III to coccyx, measured 2.5 x 2.0 cm, with slough present. The form indicated the wound was first observed on 5/16/22. There was no indication of a treatment and/or dressing change being completed as the the Current Treatment Plan stated N/A. There were no other Weekly Wound Observation forms completed on this resident for the duration of his stay. An Initial Wound Evaluation & Management Summary, dated 5/18/22, indicated the resident was seen by a wound physician. The form indicated the resident presented with a "full thickness" sacrum wound which measured 2.0 x 0.2 cm, with moderate serous exudate, with 100% of the dermis/subcutaneous tissue effected. The treatment orders were to apply calcium alginate and cover with island gauze, daily, for 30 days. In addition, the form indicated the resident had MAD-Moisture Associated Dermatitis (inflammation and erosion of the skin caused by prolonged exposure to moisture) and the			

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	ordered/treatment was to apply house barrier cream to the MAD area daily. The plan of care was wound healing evidenced by decrease surface area of the wound and/or decrease in the percentage of necrotic tissue. Recommendations were to off-load wound; reposition per facility protocol. A Progress Note dated 5/18/22 at 8:28 P.M. indicated " ...While doing rounds with the NP [Nurse Practitioner] resident bottom was noted to be excoriated as well as the groin area. This nurse cleaned the resident and cream was applied. Aide was educated about the importance of keeping the resident clean and dry ...." A Progress Note, dated 5/19/22 at 4:50 P.M., indicated "...Dr. prescribed Calmoseptine [skin barrier cream] three times a day and as needed due to resident having rash to groin area and buttock. Responsible parties notified...." A Progress Note, dated 5/19/22 at 8:42 P.M., indicated Calmoseptine was not available. A NAR (Nutrition At Risk) Note, dated 5/20/22 at 1:17 P.M., indicated Prostate 30 ml BID was added on 5/20/22. NAR Note indicated " ...Skin status: 5/16 wound observation notes stage III open area to coccyx...." A Wound Evaluation & Management Summary, dated 5/25/22, indicated the sacrum, full thickness, wound measured 1.5 x 0.7 x 0.2 cm, had moderate serous exudate and wound was improving. Continue treatments daily for 23 days. The MAD progress had "deteriorated and increased in size and severity of effective area. Treatment was to use the house barrier cream.			

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	A Head to Toe Weekly Skin Assessment, dated 5/31/22 at 4:59 P.M., indicated "admitted with wound, site: coccyx with skin breakage". There were no other descriptions or measurements of the wound. After 5/31/22 there were no other skin or wound assessments, by facility nursing staff, documented. The May Treatment Administration Record (TAR) indicated " ...Protective skin barrier ointment after each incontinent episode, prn [as needed] ...." The start date was 5/5/22 and there were no nurse's initials indicating the treatment was completed. The May Medication Administration Record (Mar) indicated on 5/19/22 there was a new ordered added which stated Calmoseptine Ointment, apply to groin area/buttock three times a day (at 8:00 A.M., 12:00 P.M. and 8:00 P.M.), cleanse injured area, pat dry then apply cream. The treatment started on 5/19/22 at 8:00 P.M., on 5/21, 5/22 and 5/29 the MAR indicated the treatment was completed only twice on those days. Niether, the MAR or TAR for May had the order for Prostat nor documentation indicating the resident was receiving the supplement for wound healing. A Wound Evaluation & Management Summary, dated 6/1/22, indicated the full thickness sacrum wound measured 1.2 x 0.8 x 0.2 cm, had 20% slough and 80% dermis/subcutaneous tissue. The Summary indicated " ...This wound is in the inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm. An excisional debridement was explained to the resident who agreed to the procedure. There was no change in the treatment of the wound. The Moisture Associated Dermatitis had			

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	increased in "size and severity" of the effected area and the treatment was to continue the house barrier cream. A Physician Note/Exam form, dated 6/2/22, indicated the resident was seen at the facility as a 30 day follow-up. The form's skin assessment indicated the resident had no cellulitis. There was no mention of the pressure ulcer and/or treatment on this form. A Wound Evaluation & Management Summary, dated 6/8/22, indicated the full thickness sacrum wound measured 2.0 x 2.0 x 0.2 cm, had 20% slough and 80% dermis/subcutaneous tissue, and had deteriorated. Again, an excision debridement procedure was explained to the resident, and he agreed to the procedure. A Group 2 mattress and gel cushion to chair were added to the recommendations. The treatment remained the same. The June TAR indicated " ...Protective skin barrier ointment after each incontinent episode, prn [as needed] ...." The start date was 5/5/22 and there were no nurse's initials indicating the treatment was completed. The June MAR indicated the treatment was completed as ordered on 6/1/22, then only twice on 6/2/22 and after 6/2/22 there were no other documentation indicating the Calmoseptine ointment had been applied as ordered. A June Certified Medical Technician (CMT) form indicated " ...Prostat two times a day related to muscle weakness ...." There was no documentation indicating the Prostat had been administered.			

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	On 9/14/22 at 11:18 A.M., an interview was conducted with the Regional Nurse and the Clinical Nurse Specialist. The Clinical Nurse Specialist indicated the CMT note, which had the order for Prostat, dated 5/20/22, should have been seen by the nurse and documented as administered twice a day. She confirmed there was no documentation of the Prostat being provided to the resident. The Regional Nurse indicated when the Dietician recommended the Prostat, for wound care, the order should have been added to the MAR and administered as ordered. Both agreed there was no documentation for wound treatments being completed, such as medi-honey/calcium alginate/dressing, nor just calcium alginate/dressing. Both indicated the wound barrier cream was also not provided as ordered consistently. During an interview, on 9/14/22 at 11:37 A.M., the Wound Physician indicated he was the one who had evaluated the wounds on Resident B. He indicated he documented the wound as being 1 day old, as he was relying on the nurse for date the wound was acquired. He indicated his notes were documented electronically, then uploaded into their system. Otherwise, after he leaves the facility, he documents the notes and the facility was given a password to access his notes regarding measurements treatment etc. The Physician indicated he also communicated with the facility wound nurse and/or DON (Director of Nursing) prior to leaving the facility, to ensure staff are aware of his treatments etc. The Wound Physician indicated there were no delays in staff knowing the wound treatments. The Wound Physician indicated the term "full thickness" indicated the dermis and epidermis were gone and could view the subcutaneous, fatty tissues and confirmed this is what Resident B's wound was			

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	diagnosed as a full thickness pressure wound with MAD surrounding the pressure area. On 9/12/22 at 1:05 P.M., the Director of Nursing (DON) provided a policy titled, "Prevention of Pressure Ulcers/Injuries", dated July 2017, and indicated the policy was the one currently used by the facility. The policy indicated "...Moisture 1. Keep the skin clean and free of exposure to urine and fecal matter...Nutrition...2. Include nutritional supplements in the resident's diet to increase calories and protein...Mobility/Repositioning 1. Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences...Monitoring 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis...." On 9/12/22 at 1:07 P.M., the Director of Nursing (DON) provided a policy titled, "Physician Orders", dated 6/22/22, and indicated the policy was the one currently used by the facility. The policy indicated "...MAR/TAR: Medication Administration Record/Treatment Administration Record - the legal medical record for recording medications and treatments...Policy Interpretation and Implementation:... 3. Execution of Order and Notifications a. The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand- off to the next nurse b. Contact laboratory services, radiology services, pharmacy services, therapy or other outside vendors as required to execute the medical order c. Update eMAR/eTAR with changes or new orders			

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	d. Notify internal staff of changes/updates as appropriate e. Notify resident/resident representative of changes or new orders as appropriate f. Notify attending or other providers as appropriate g. Document notifications and appropriate assessments in the medical record On 9/14/22 at 3:23 P.M., the Regional Nurse provided a policy titled, "Pressure Ulcers/Skin Breakdown - Clinical Protocol", dated July 2017, and indicated the policy was the one currently used by the facility. The policy indicated "...Documentation The following information should be recorded in the resident's medical record utilizing facility forms: 1. The type of assessment (s) conducted. 2. The date and time and type of skin care provided, if appropriate 3. The name and title (or initials) of the individual who conducted the assessment 4. Any change in the resident's condition, if identified. 5. The condition of the resident's skin (i.e., the size and location of any red or tender areas), if identified. 6. How the resident tolerated the procedure or his/her ability to participate in the procedure. 7. Any problems or complaints made by the resident related to the procedure. 8. If the resident refused the treatment, the reason for the refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal. 9. Observations of anything unusual exhibited by the resident			

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	10. The signature and title (or initials) of the person recording the data. 11. Initiation of a (pressure or non-pressure) form related to the type of alteration in skin if new skin alteration. This Federal tag relates to complaint IN00389408. 3.1-40(a)(2) 3.1-40(a)(3)			